Washington State Department of Health

Send completed forms to DOH Communicable Disease Epidemiology
Fax: 206-418-5515

Arboviral Disease

County

LHJ Use ID _____
☐ **Reported to DOH** **Date** ___/___/___
LHJ Classification ☐ **Confirmed** ☐ **Probable**
By: ☐ **Lab** ☐ **Clinical** ☐ **Other:** _____
Outbreak # (LHJ) _____ **(DOH)** _____

DOH Use ID _____
Date Received ___/___/___
DOH Classification
☐ ***Confirmed***
☐ ***Probable***
☐ ***No count; reason:***

REPORT SOURCE

Initial report date ___/___/___
Reporter (check all that apply)
☐ Lab ☐ Hospital ☐ HCP
☐ Public health agency ☐ Other
OK to talk to case? ☐ Yes ☐ No ☐ Don't know

Investigation start date: ___/___/___

Reporter name _____
Reporter phone _____
Primary HCP name _____
Primary HCP phone _____

PATIENT INFORMATION

Name (last, first) _____
Address _____ ☐ Homeless
City/State/Zip _____
Phone(s)/Email _____
Alt. contact ☐ Parent/guardian ☐ Spouse ☐ Other Name: _____
Phone: _____
Occupation/grade _____
Employer/worksite _____ School/child care name _____

Birth date ___/___/___ Age _____
Gender ☐ F ☐ M ☐ Other ☐ Unk
Ethnicity ☐ Hispanic or Latino
☐ Not Hispanic or Latino
Race (check all that apply)
☐ Amer Ind/AK Native ☐ Asian
☐ Native HI/other PI ☐ Black/Afr Amer
☐ White ☐ Other

ARBOVIRUS TYPE (Yellow Fever and West Nile Virus covered on separate forms)

☐ Western Equine Encephalitis ☐ Eastern Equine Encephalitis ☐ St. Louis Encephalitis
☐ Japanese Encephalitis ☐ Dengue Fever ☐ LaCrosse ☐ Other: _____

CLINICAL INFORMATION

Onset date: ___/___/___ ☐ Derived Diagnosis date: ___/___/___ Illness duration: _____ days

Signs and Symptoms

Y	N	DK	NA	
☐	☐	☐	☐	Fever Highest measured temp: _____ °F Type: ☐ Oral ☐ Rectal ☐ Other: _____ ☐ Unk
☐	☐	☐	☐	Nausea
☐	☐	☐	☐	Vomiting
☐	☐	☐	☐	Headache
☐	☐	☐	☐	Stiff neck
☐	☐	☐	☐	Eyes sensitive to light (photophobia)
☐	☐	☐	☐	Confusion
☐	☐	☐	☐	Muscle aches or pain (myalgia)
☐	☐	☐	☐	Joint pain
☐	☐	☐	☐	Seizures new with disease
☐	☐	☐	☐	Rash

Predisposing Conditions

Y	N	DK	NA	
☐	☐	☐	☐	Viral encephalitis in past (e.g., dengue, SLE, Y.F.)

Clinical Findings

Y	N	DK	NA	
☐	☐	☐	☐	Abnormal neurologic findings
☐	☐	☐	☐	Altered mental status
☐	☐	☐	☐	Ataxia
☐	☐	☐	☐	Paralysis or weakness
☐	☐	☐	☐	Rash observed by health care provider
☐	☐	☐	☐	Lymphadenopathy
☐	☐	☐	☐	Arthritis or arthralgia
☐	☐	☐	☐	Meningitis
☐	☐	☐	☐	Encephalitis or encephalomyelitis
☐	☐	☐	☐	Jaundice
☐	☐	☐	☐	Liver abnormality or failure
☐	☐	☐	☐	Kidney (renal) abnormality or failure
☐	☐	☐	☐	Hemorrhagic signs

Clinical Findings (cont'd)

Y	N	DK	NA	
☐	☐	☐	☐	Complications, specify: _____
☐	☐	☐	☐	Admitted to intensive care unit

Hospitalization

Y	N	DK	NA	
☐	☐	☐	☐	Hospitalized for this illness

Hospital name _____
Admit date ___/___/___ Discharge date ___/___/___

Y	N	DK	NA	
☐	☐	☐	☐	Died from illness Death date ___/___/___
☐	☐	☐	☐	Autopsy Place of death _____

Vaccinations

Y	N	DK	NA	
☐	☐	☐	☐	Japanese encephalitis or yellow fever vaccine in past Type: _____ Date ___/___/___

Laboratory

P = Positive O = Other, unknown
N = Negative NT = Not Tested
I = Indeterminate

Specimen type _____ Specimen type _____
Collection date ___/___/___ Collection date ___/___/___

P	N	I	O	NT	
☐	☐	☐	☐	☐	Abnormal CSF Profile: wbc ____ (% lymph_____ % neutr____) rbc ____ prot ____ gluc ____
☐	☐	☐	☐	☐	**Viral antibodies with single elevated titer or ≤ 2-fold increase *or* virus-specific IgM by EIA without IgG confirmation (serum) [*Probable*]**
☐	☐	☐	☐	☐	**Viral IgM by EIA (CSF)**
☐	☐	☐	☐	☐	**Viral antibodies with ≥ 4-fold rise (serum pair)**
☐	☐	☐	☐	☐	**Viral IgM by EIA *and* IgG by another assay (serum)**
☐	☐	☐	☐	☐	**Virus culture or PCR (clinical specimen)**

INFECTION TIMELINE

Enter onset date (first sx) in heavy box. Count backward to determine probable exposure period

	Exposure period		onset
Days from onset:	-15	-2	
Calendar dates:			

EXPOSURE (Refer to dates above)

Y N DK NA

☐ ☐ ☐ ☐ Travel out of the state, out of the country, or outside of usual routine
Out of: ☐ County ☐ State ☐ Country
Dates/Locations: _____
_____
_____

☐ ☐ ☐ ☐ Case knows anyone else with similar symptoms

☐ ☐ ☐ ☐ Insect or tick bite
☐ Mosquito ☐ Tick
☐ Other: _____
☐ Unknown insect or tick type
Location of insect or tick exposure: _____
_____
Date of exposure: ___/___/___

☐ ☐ ☐ ☐ Outdoor or recreational activities (e.g. lawn mowing, gardening, hunting, hiking, camping, sports, yard work)

☐ ☐ ☐ ☐ Blood transfusion or blood products (e.g. IG, factor concentrates)
Date of receipt: __/__/__

☐ ☐ ☐ ☐ Organ or tissue transplant recipient
Date of receipt:__/__/__

☐ ☐ ☐ ☐ If infant, birth mother had febrile illness

☐ ☐ ☐ ☐ If infant, confirmed infection in birth mother

☐ ☐ ☐ ☐ If infant, breast fed

☐ ☐ ☐ ☐ Foreign arrival (e.g. immigrant, refugee, adoptee, visitor) Specify country: _____

☐ ☐ ☐ ☐ Occupational exposure
Lab worker ☐**Y** ☐**N** ☐**DK** ☐**NA**
Other: _____

☐ **Patient could not be interviewed**
☐ **No risk factors or exposures could be identified**

Most likely exposure/site: _____ **Site name/address:** _____

Where did exposure probably occur? ☐ In WA (County: _____) ☐ US but not WA ☐ Not in US ☐ Unk

PUBLIC HEALTH ISSUES

Y N DK NA

☐ ☐ ☐ ☐ Neonatal
Delivery location: _____

☐ ☐ ☐ ☐ Pregnant
Estimated delivery date ___/___/___
OB name, address, phone: _____
_____

☐ ☐ ☐ ☐ Did case donate blood products, organs or tissue (including ova or semen) in the 30 days before symptom onset Date: ___/___/___
Agency and location: _____
Specify type of donation: _____

☐ ☐ ☐ ☐ Outbreak related

PUBLIC HEALTH ACTIONS

☐ Breastfeeding education provided
☐ Notify blood or tissue bank
☐ Other, specify: _____

NOTES

Investigator _____ **Phone/email** _____ **Investigation complete date** ___/___/___

Local health jurisdiction _____ **Record complete date** ___/___/___